

DELAWARE STATE MEDICAL JOURNAL

Official Organ of the Medical Society of Delaware

INCORPORATED 1789

VOLUME III
NUMBER 1

JANUARY, 1931

Per Year \$2.00
Per Copy 20c

CONTENTS

SUPPURATIONS WITHIN THE CHEST	1	WOMAN'S AUXILIARY	12
CONCERNING THE TREATMENT OF ABORTIONS	6	MISCELLANEOUS	14
EDITORIAL	9	PSYCHIATRIC OBSERVATION CLINIC	14
DELAWARE PHARMACEUTICAL SOCIETY	12	BOOK REVIEWS	19

Entered as second-class matter June 28, 1929, at the Post Office at Wilmington, Delaware, under the Act of March 3, 1879. Business and Editorial offices, 1022 duPont Building, Wilmington, Delaware. Issued monthly.

Resolved

1. Taste the Syrup.
2. Test the Tablets for Toleration
3. SEND TODAY FOR BOTH

COMPOUND SYRUP OF CALCREOSE is a tasty, effective cough syrup that does not nauseate.

Each fluid ounce represents Calcreose Solution, 160 mins.; Alcohol, 24 mins.; Chloroform, approximately 3 mins.; Wild Cherry Bark, 20 grs.; Aromatics and Syrup, q. s.

TABLETS CALCREOSE 4 GRS. provide the full expectorant action of creosote in a form which patients tolerate.

Each tablet is equivalent to 2 grains of creosote combined with hydrated calcium oxide.

Doctor—Check your choice of offers and return the lower corner with anything showing your name and address.

We do not advertise to the laity.

- ☐ Free sample of both.
- ☐ Enter order for 1M Calcreose Tablets, price \$3 postpaid, and include free 1 doz. 3 oz. Syrup for clinical trial.

THE MALTBY CHEMICAL COMPANY, Newark, N. J.



Curiosity GAVE THE WORLD A NEW AND IMPORTANT MEDICINE . . . PHYSIOLOGICAL STANDARDIZATION MADE THIS MEDICINE UNIFORMLY POTENT . . .

OLD MOTHER HUTTON, the Shropshire herb-woman, guarded her secret jealously. Had not her herb tea relieved an Oxford dean of his dropsy, when all other remedies had failed? To satisfy his curiosity, Dr. William Withering sought out the old woman, nearly 150 years ago. At first she stubbornly refused to talk to him. But finally one argument prevailed. There was the clink of golden sovereigns in Mother Hutton's palm, and the cherished recipe was his!

Withering saw that the crudely written scrawl called for twelve common herbs and plants. After long and patient trial he found eleven of them medicinally worthless. But in the twelfth, the purple foxglove, he found a new and powerful drug, now more commonly known as digitalis.

Physicians welcomed Withering's contribu-

tion to medicine, but they soon found that the use of digitalis was attended by a serious difficulty. Extracts made from the drug were by no means uniform in potency. Some were too weak; others were much too strong for safety.

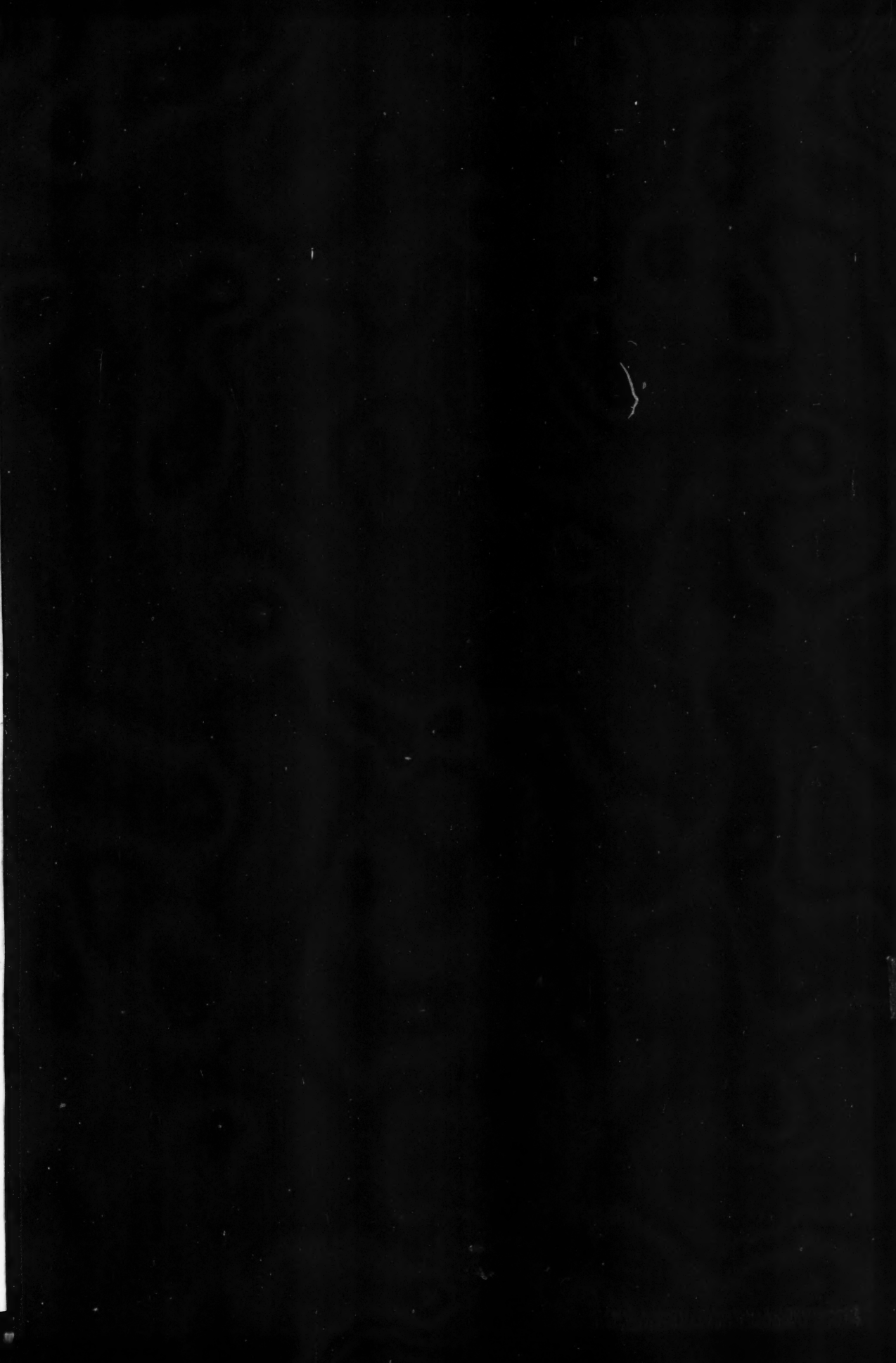
For over a century, physicians and pharmacists grappled with the problem of making uniform extracts of digitalis. Then, in 1898, exactly 113 years after Withering's discovery, the Parke-Davis medical research laboratories announced the first standardized tincture of digitalis.

Parke, Davis & Company is justly proud of the part it has played in introducing, developing and extensively applying the principles of chemical and physiological standardization. No product leaves our laboratories until there have been applied to it all the tests that scientific investigation has found necessary to determine its purity and potency as a medicinal agent.

PARKE, DAVIS & COMPANY

DETROIT NEW YORK CHICAGO KANSAS CITY ST. LOUIS BALTIMORE NEW ORLEANS
MINNEAPOLIS SEATTLE In Canada: WALKERVILLE MONTREAL WINNIPEG

The world's largest makers of pharmaceutical and biological products



DELAWARE STATE MEDICAL JOURNAL

*Owned and Published by the Medical Society of Delaware
Issued Monthly Under the Supervision of the Publication Committee*

Volume III
Number 1

JANUARY, 1931

Per Year \$2.00
Per Copy 20c

SUPPURATIONS WITHIN THE CHEST*

ARTHUR M. SHIPLEY, M. D.,
BALTIMORE, Md.

MEMBERS OF THE SOCIETY:

I will start out with pyopericardium, which is a suppurative condition within the pericardial sac, as you know. This condition has been largely overlooked by the medical profession until quite recently. Recently Dr. Nathan Williams and I were able to find only 116 cases in the literature of suppurative condition within the pericardial sac diagnosed and operated on.

If you take the trouble to look over the records of the pathological reports of big hospitals, you will find that a very high percentage of cases exist of overlooked suppurations within the pericardial sac. Without doubt at autopsy many patients have had suppurations within the chest, osteomyelitis or other infections having to do with the cardiac organs.

These individuals with suppurations within the pericardial sac produce a group of symptoms that are almost diagnostic if you just have your attention called to the possibility that your patient may have a pyopericardium, and not overlook it, and then you can pick up cases of suppurative condition which can be sent to the hospital and drained by a surgeon, and in many instances these cases will recover.

To give you an idea how good the prognosis is, I have operated on eleven cases and it happens that is the largest number which has been operated on by any one surgeon. That does not give me any particular credit and I don't take credit for it because the diagnosis of this condition has been made in almost every instance by the medical service and it is an instance of what can be done with an organized unit where the roentgenological service, the medical service, and the surgical service work hand in hand and all three are keenly alert for the unusual complications of suppurative condition.

These cases were practically all young. The

youngest was four years old and the oldest was thirty, and of the eleven, seven recovered and four died, so that gives you a rather surprising prognosis, but when you look up the record of the 120 cases that have been gathered together from the literature, the recoveries ran from 50 to 60 per cent, so the prognosis is better than you would suppose, thinking of this serious condition of a lot of pus between the pericardium and the heart.

Suppose a patient is still not completely recovered from pneumonia, influenza, or empyema complicating any condition, osteomyelitis, peritonitis, subphrenic abscess, or peritonitis without subphrenic abscess, and after the cavities are drained and you expect the temperature to drop and the pulse to improve, and you think the patient should be getting better, but the patient still remains critically ill and the pulse and temperature are still up. You have hunted everywhere for some explanation of this continued illness when the pneumonia is better. Then your first thought should be, after excluding the general blood infections, a suppurative pericarditis.

These patients have a rather hurried breathing. They breathe rather quickly and if you percuss them, you will find that the area of dullness of the heart extends rather far out here in the upper left chest. It may extend almost up to the clavicle, up to the first or second rib, and that the area of dullness about the heart is very broad at the base.

You remember anatomically that your heart is pear-shaped, with the base up and the apex down, that the pericardium is somewhat differently shaped. The pericardium in the healthy chest hugs the heart, but as soon as there is an effusion in the pericardial sac, fluid collects in three spaces, between the pericardium and the heart, behind the heart on the right, behind it on the left, and low down in the pericardial sac. The bulging will extend fairly high up on the left side, so if you see an xray of a patient with pus, you will have the shadow of the heart exactly reversed. It will be a shadow with a broad base

* Read before the Medical Society of Delaware, Dover, October 15, 1930.

D 610
D 343
V. 3-4

and a rather narrow line above, and as soon as you see that sort of shadow, you begin to suspect you are dealing with effusion of the pericardium.

If you suspect an effusion of the pericardium, **what will you do?** Pericardicentesis is a procedure which can be done, but it is always dangerous unless done skilfully. If you think how dangerous it might be to thrust a needle in between the ribs and have it enter the pericardial sac without touching the heart, you will realize it should not be done without considerable training and knowledge of what you are doing. I have never attempted it or expect to attempt it. The medical man does it occasionally because he has done many of them. It is much more serious than the operation of opening the pericardium, and very much more dangerous. You can see perfectly well if you thrust a needle, for instance, in between the ribs, the ribs fix the position of the needle, but the heart is moving rapidly in the chest so that the heart is likely to rub across the point of the needle. Hark back to your anatomy or gross pathology and you will remember the heart has certain large vessels on the surface, especially between the two ventricles and the auricles and ventricles, so you know what would happen if the point happened to scratch across the needle, with the point of the needle fixed, so that pericardicentesis should be done only with a good deal of training and not lightly.

What we do surgically is a pericardotomy. There we go into the pericardium directly and operate under the eye. We watch the point of the knife at every step. Again if you hark back to your anatomy, you will remember the two pleura come together here in the chest and from the top of the chest about the level of the second rib down to the fourth, that these two pleura are in contact. The pleura, of course, do not move. It is the lung that moves in the pleura, but the pleura stays in a rather fixed position. It is attached definitely unless tremendously distended by fluid. Then about the level of the fourth rib the two pleura begin to diverge away from each other, a little to the left of the midline and you have a triangle in the mid front of the chest with its base up and apex down, and about the fourth rib, and with its base exactly on a level with the point where there is the ensiform cartilage, sometimes called the triangle of safety.

The two pleuras have separated and there is none there, and that is occupied by a little connecting tissue. After you take away some of

the cartilages of the ribs, a few lymphnodes are there, and that is a portion of the anterior mediastinal space, and through this area you can reach the pericardium without opening the pleura.

If the patient has not already an empyema and the cavities of the pleura are free from infection, and, by operating, you open the pleura, and after that they become infected, you give to a patient already severely ill at the same time an empyema, and an open pyohemothorax, with all the risk of mediastinal flutter, added to a heart already tremendously overburdened by the compression upon it.

These patients with fluid in their pericardial sac often have a pulse that is characteristic and many men will suspect the diagnosis from three things, from the peculiar breathing, a hurried breathing, not shortness of breathing. You have to see it to describe it exactly. It is a hurried sort of breathing though the patient is lying fairly quiet, not sitting up, and they are dyspneic, grabbing something to help them breathe, lying quietly and breathing quickly, as if short of breath, as if they had just stopped running. There is that queer picture. At the same time they are likely to be cyanotic, because the heart is compressed by the wall of fluid and the cyanosis depends largely on the quantity of pus present. If there is a large amount of pus, there may be considerable cyanosis.

There is this bulging on the left side and a pulse that varies with the breathing. Ordinarily when you feel the pulse of a patient, sick or well, one beat follows the other with about the same force. It may be fast or slow, and the pulse will run pretty smoothly across the pulse chart. If there is any condition of pressure upon the heart such as is put upon it by the blood after a gunshot wound or by fluid, where the fluid has collected in the pericardial sac but is not pus, these patients will have a pulse varying with the breathing. When they take a breath, the lungs fill up with air and the heart is able to throw out less blood and during that time the pulse drops in the volume under your finger until you may scarcely feel it, and as the patient exhales and a vacuum is created, the heart has more room in the chest to expand and the pulse comes up, so it comes up under your finger and runs down, a pulse that varies with the breathing and that pulse rate will often be very characteristic and almost diagnostic.

The operation is not difficult. It is simple. It

is one which we do under local or under the new anaesthetic which has recently been described, ethyl-alcohol. That makes a very good anaesthetic with otherwise good kidneys and heart muscle. You make an incision, using one of two operations, really one of four, but we have used two. If it is a child, the best thing to do is a midline incision from the base of the ensiform up two or three inches, and then uncover the sternum and with an ordinary trephine from an ordinary bursa, you open it, and trephine an opening in the sternum a little to the left of the midline and just over the triangle of safety, which we have described, and when you get through the sternum, you will come down upon the anterior mediastinum. You take a pair of rongeur forceps and bite away room enough so you can operate in the space. That has advantages in the child. If you put a little novocain under the periosteum, the bone itself isn't sensitive and you can put the burr through the bone without producing pain.

The first one I did was on a little excitable Italian boy, four years old, and I cite that to show you can do it without much trouble. He had some morphia, but not enough to make him insensitive, and he did not struggle or cry, and I think it was accomplished without pain.

I have a different story to tell in only one patient, a young colored girl who became restless and upset late in the operation. She started to struggle, more through fright than pain. The rest were under local except the last case recently which was under tribrone ethyl-alcohol, and this patient did very well.

When you get through the bone when you are doing the first one or the second one, you are a bit anxious. You come down after you get through the sternum and come down on the anterior mediastinum and you are sure there is no pleura in the way. You can recognize it and distinguish it from the pericardium because it is translucent and you can see the edge of the lung coming up under the pleura, but the pericardium is opaque, grayish in color. You cannot see the heart through it. It is thicker and not translucent like the pleura, so if you look and you see no lung moving, you take your scalpel point and push back the connective tissue and come down on the dense, firm, grayish-white membrane. You put your finger on it and you think there couldn't possibly be any fluid in the pericardial sac because the heart is beating right up under your hand, and you think some mistake

must have been made and there couldn't be any fluid there. Here is the heart right up under your finger. You put your finger on the thing and the heart is going very fast, of course, coming up against it, but remember that the fluid is never in front of the heart and that is why the needle is dangerous. It is lateral to the heart, and behind it and below it, and there is never any wall of fluid between the anterior mediastinum and the heart no matter how large a collection of fluid you have. I have always found the heart right up against the anterior wall of the pericardium.

Another thing that disturbs you, you think, "Suppose it is inherently pericardiac, how will I know that I have cut enough, and might I not go straight through into the heart?" But, you are operating over ventricles, not over auricles, and near the apex, and there the heart muscle is very thick, and at the apex there is an inch or an inch and a half of solid muscle to which the ventricles are allied, so you might nick the heart, if the heart and pericardium were adherent, and do no damage.

In acute recent suppurative pyopericardium you will rarely find adhesions between the heart and the anterior wall of the pericardium. As soon as you go through, your diagnosis is established at once, because the action of the heart immediately begins to dump out pus and sometimes you will have to duck your face away to keep your glasses from being covered, if you happen to wear glasses, as I do.

Then you have the question of drainage. Some of the cases we didn't drain and we had to put a drain in afterwards. Altogether that procedure is a very good one in children; not in adults, because your finger isn't long enough, the sternum won't give in, and after you open the pericardium, you must be able to swing your finger around the heart and be sure there are no pockets, and you want to be sure you do not leave a suppurative pericarditis pocket because, if you do, you will have to go back after that pocket.

The best way in an adult is to do the Kondorsiphoid approach, take away the cartilage on the left side. It is the seventh that comes up and joins. You take away the seventh, and sixth, and fifth cartilages against the sternum and take a rongeur and take a half-moon shaped piece of bone out of the lateral wall of the sternum and you will see the pleura and you may have to ligate that and slide it out of the way and the

pleura out of the way, and don't incise the pericardium until you are sure you are down on that same dense, firm, grayish member that is not translucent, and in putting your drains in at the bottom, the patient partially recumbent has a tendency to drain out from the bottom of his pericardial sac.

There are many, many suppurations within the chest. I have a collection of slides here which include pericardium lung abscess, bronchiectasis, and the walled off or localizing empyemas. These empyemas are commonly overlooked, especially in children. In children empyema is overlooked because of the fact that the sounds are relatively harsh anyway and are easily heard through the wall of fluid, and if you percuss the child, you will bring out the resonance of the lung behind the fluid and very often on the ordinary gross listening and ordinary gross percussion, you won't make out very much difference between the pus side and the good side. Of course, when the empyema becomes massive and the chest is cyanotic and the patient is ready to die, the diagnosis is easy enough, but I am talking about the walled off localized empyemas. They may be seen anywhere in the chest, on either side, and they are commonly seen over the upper portion of the lung and a common site happens to be in the neighborhood of the axilla. The wall of fluid is usually thin, and these are overlooked again and again because the man who uses the needle, puncturing the pleura for pus, is likely to put novocain in and let the needle slip through and he will go straight through the wall of the pleura to the lung and get a dry tap. This will happen with children coming to the clinic for a number of days. If he tilted his needle at the place where he suspected pus was present and the xray showed some evidence of cloudiness, if he slipped it through the rib and thrust it down rather than up (and when he tilts it up, he is likely to injure the intercostal rib above), he would be much more likely to get the pus.

This condition of a walled off empyema is very important and common. I had a man some time ago on whom I had operated for an ordinary free empyema. I operated on him on the left side. I took out the eighth rib back here and got into a lot of pus. I put my finger in here and felt a membrane that felt too dense for diaphragm and yet I was afraid to go through it. I left it alone, and here was the man after we had drained the

pus away. He not only had a free empyema, but a walled off empyema below, the width of a rib or a rib and a half from the diaphragm. There were two distinct pockets on one side and one so low down that with the finger in the chest you felt it must be diaphragm because it was where the diaphragm should be, but the diaphragm was pushed down and there was a collection of pus separate and distinct.

Sometimes they are tucked away close to the spine behind and unless your patient is very carefully examined by a clinician and by the xray, these may be overlooked until very grave damage is done.

The most difficult group of cases along this line of chest suppurations is that of patients who have had a surface infarct. Infarcts are of three groups: the big one of the pulmonary artery, where the patient is dead before the doctor gets to him. Then there is the one where by the time you think the patient is getting better there is a massive embolus and the patient sometimes lives only ten or twelve minutes in great discomfort and dies.

Then there is the class of infarcts of the lung, not so large, where the embolism washes off not large enough to block a pulmonary, but a branch, or you may have a third, or fourth, or one-half of one lung blocked. They become suddenly dyspneic, the pulse goes up and they look as if they would die, but usually they recover unless another portion of the lung is blocked. If that embolism happens to be an infected embolism and the infarct becomes infected from that, you are likely to develop a surface suppuration in the lung, with the base at the chest wall and the apex in toward the cardium of the lung and here you have a localized surface suppuration. It doesn't begin in the pleura but in the lung, but it is on the surface of the lung, and these patients have localized pleurisy. You can hear it at the point. They spit up bloody sputum and most of them go on and get along all right unless they kick out another infarct, but every once in a while the surface infarcts become infected and there you are dealing with something in the xray and at operation. It is scarcely possible to say whether the original condition was walled off or a suppuration of the lung. (Applause.)

DISCUSSION

CHAIRMAN CONWELL: This is a very interesting and instructive address. Do any members

of the Society wish to discuss it, or ask any questions?

DR. W. E. BIRD (Wilmington): I feel the question should not pass without some discussion. Dr. Shipley has presented two very interesting and important subjects in a very interesting manner. The average general surgeon sees very few of the pyopericardium cases, and probably even then has only a limited opportunity to operate on them, and the average small hospital has much greater difficulty in getting the consent of the patient or the parent.

Personally I have tapped a few pericardiums by using a needle with a guard to it so as to obviate some of the risk of having a sharp needle puncture one of the vessels on the surface.

The literature on this subject is quite scarce. I do recall one article some eight or ten years ago, I believe, by Poole, of New York, who recorded some five or six cases of pyopericarditis with, I think, four out of five recoveries.

That paper gave me a point in the drainage problem you wouldn't think of, perhaps. If the patient is in a recumbent position, there is a lower level of the pericardium at the base, and Dr. Shipley stresses the point that you should be able to swing your finger around the entire heart, including the base, otherwise you may overlook this deeper, definite drop in the level of the floor of the pericardium.

I congratulate the author on his most excellent results; and may I add my personal appreciation of his presenting this subject in such a masterful way?

DR. R. B. HOPKINS (Milton): I should like to ask whether the blood count in the diagnosis has been of great assistance in diagnosis.

DR. H. V. P. WILSON (Dover): I should like to ask Dr. Shipley whether the end-result on the heart was affected much by the presence of adhesions afterwards.

DR. A. M. SHIPLEY: The blood count doesn't help you. The chart and the blood count and the whole picture tells you there is pus somewhere, but your job is to find out where it is and, of course, you have to differentiate the pyopericardium from a big heart, and a great many other things. I haven't time to go into that in a short address, but the problem is to differentiate this big shadow and find out whether it is a pyopericardium, and you know from the temperature and leucocyte count and all the other things, you are dealing with suppurations. As a matter of

fact the thing complicates itself. Pericarditis is usually secondary and you rarely have a primary suppurative pyopericardium without complications with pneumonia.

You might go around and suspect an empyema and finally your attention is centered on the enlarged heart shadow, and then it is your job to make a diagnosis.

In Baltimore the group of us who work together on most of the cases has been able to make the diagnosis on the clinical findings rather than on the puncture.

As to the other question, that is a most pertinent question. I followed up all of these cases. For instance, the next to the last case I operated on is that of a nurse in one of the Baltimore hospitals. I have been able to see her every few days. She was kept from doing any work at all for four months after operation. She was short of breath during the four months, and was bound to have adhesions, between the heart and pericardium, which are noticeable. It is not so bad if there are no adhesions between the pericardium and the chest wall. If the heart is adherent to the pericardium and the pericardium to the chest wall, you have an entirely different clinical entity, and that is a question that calls for resection to liberate the heart, but adhesions between the heart and pericardium are not very disabling unless the pericardium itself is fixed to some of the tissues on the outside.

The boy four years old had so much trouble for three or four months that he had to be tapped three or four times. He had an acutely disabled heart due to suppuration and adhesions, possibly because two drains were put in, one on each side of the heart, and he had almost complete cardiac disability for four or five months. He was the first case I operated on and he is a perfectly well boy so far as his activities are concerned. I am quite sure if a section were done on him, you would find some adhesions between the heart and the pericardium. I doubt that they would be dense or extensive, but you could scarcely imagine so much of an infection in so serious a member without leaving some adhesions.

So in most of these cases that have recovered, they have been more than temporarily disabled. If you look up the literature about it, you will find only a small percentage of them have been followed over a long period of years and there is not much in the literature about it, but where a check has been made, a surprisingly large

number of them have continued to live throughout the rest of their lives (to use an Irish expression) without particular difficulty unless they have adhesions between the pericardium and the chest wall, in which instance they are, of course, disabled.

CONCERNING THE TREATMENT OF ABORTIONS*

G. METZLER, M. D.,
BRIDGEVILLE, DEL.

Abortion is one of the most frequently occurring conditions met with in the practice of medicine and deserves much more attention than it has so far received in medical discussions. When we consider the fact that in every four or five pregnancies one of these is terminated before the end of the third month and that practically one-half of the child-bearing women have one or more abortions, we recognize the importance of this condition and its treatment.

Prophylaxis is first to be considered in any modern treatment. The prophylactic treatment of abortion may be begun before conception. When a patient presents a history of previous abortions a careful examination is necessary. A retroverted uterus may be replaced with a pessary or a suspension may be done if necessary. In cases where retroversion is noted after conception has taken place, the use of the knee-chest position is of great value. The patient should assume the position several times daily, remaining in it for about ten to fifteen minutes each time.

A small fibroid may be responsible for repeated abortions and careful examination of the uterus is necessary. If this diagnosis is established surgical correction should be attempted.

When no abnormalities can be found and a history of previous abortions is present, the patient should be cautioned about exercise, especially at the time of the expected menstruation. Intercourse should be forbidden. At times rest in bed is necessary.

In cases of suspected lues a Wassermann should be taken and if positive, anti-syphilitic treatment should be begun. Syphilis, however, rarely causes abortions but frequently brings about a premature labor.

When threatened abortion is suspected the treatment indicated is absolute rest in bed, with

liquid or soft diet, administration of sedatives, and the avoidance of purgatives.

Upon the question of position of the patient in bed there seem to be differences of opinion. Many adhere to the older method of raising the foot of the bed while Connelly in his *Treatment of Abortions* advises raising the head of the bed. He explains his viewpoint as follows: "When the head of the bed is lowered, the blood to be expelled must counteract the force of gravity. The uterus thus fills up with blood which clots and acts as a foreign body. The uterus then contracts forcibly and expels the clot and often the pregnancy. If the head of the bed is elevated the cervix is much lower than the fundus and the blood drains off and does not clot. As a result of this the uterus does not forcibly contract and regains its normal tone and when it does the partially detached placenta or decidua presses over the bleeding area and thus acts as a natural pack."

However, all these measures may fail and a threatened abortion is converted into an actual abortion, either complete or incomplete.

We will consider only the incomplete type of abortion, since the complete type is often uneventful.

On the subject of abortions, more has been written about the treatment of incomplete abortions than any other phase and yet there seems to be no agreement in the handling of these cases. At one extreme are those who advise letting the patient absolutely alone in the hope that nature will expel the retained products, and at the other extreme are those who advise curettage at once in every patient.

The ideal treatment of incomplete abortions seems to be the one which assures that all the products of conception have been removed from the uterus with the least trauma possible.

Excessive hemorrhage is one condition where immediate action is necessary. Packing the uterus and cervix under aseptic conditions with gauze treated with antiseptics, of which iodoform seems to produce the best results, effectively controls the hemorrhage and may be done without anaesthesia. This packing is removed in twenty-four hours under light anesthesia and aseptic conditions and often the retained portions are brought out with the gauze. After removing the gauze pack a sterile gloved finger may be used to explore the uterus and any retained portions

* Read before the Medical Society of Delaware, Dover, October 14, 1930.

gently loosened and removed. In this way the cervix receives no trauma and the uterus is left clean. After-care is extremely simple, consisting of rest in bed, free elimination, proper diet and possibly small doses of ergot to promote involution.

When there is considerable hemorrhage in febrile cases and the cervix is patulous, packing may be used without much danger. Febrile cases, however, rarely seem to have excessive hemorrhage.

The present day treatment of febrile cases as a whole seems to be tending toward the conservative methods. In absence of severe hemorrhage, the expectant treatment is continued until the temperature has remained normal for five or six days. While this procedure seems to produce the best results in the majority of febrile cases, there are instances where emptying of the uterus markedly shortens the febrile state.

In sapremic cases where the cervix is open and there is a foul mass of necrotic tissue retained in the uterus removal with as little instrumentation as possible, followed with iodoform packing seems to lead to rapid recovery.

Cases of general septicemia appear to yield only to the expectant form of treatment which is the one used almost entirely.

In concluding we may summarize by saying that tendencies seem to be:

1. Toward placing more importance on the prophylactic treatment of abortions than was formerly done.

2. Toward conservative methods of treatment in the majority of cases, yet varying from these in certain isolated cases.

DISCUSSION

DR. M. A. TARUMIANZ (Farnhurst): I have enjoyed Dr. Metzler's paper very much. I should like to be verified in a statement that abortion is not caused by syphilis, or it is caused by it very rarely. My understanding was that syphilis is one of the main causes of abortion. I should like to know more about that. Maybe some other members can enlighten me as to their experience also.

DR. W. E. BIRD (Wilmington): On the point of treatment, Dr. Metzler made it plain that there seemed to be two schools, or two opinions. Most of the literature I have happened to encounter in recent years seems to lay stress on the con-

servative, non-operative method. Such an authority as Gellhorn, of St. Louis, for instance, has made it perfectly clear in quoting his own cases and those of other writers, in a series numbering some five or six thousand cases in toto, that the mortality in abortions is in direct proportion to the instrumentation. He does not by that statement mean to rule out of the picture the manual removal of a clump of placenta which may be holding the cervix open so that there is continued bleeding.

His indication for interference is continued sharp hemorrhage or a small hemorrhage over a long enough time. He brings out the point that if you admit one hundred women with incomplete abortions to the hospitals and curette them, ninety-two of the hundred will come out well, without a discharge; that is, without a discharge at the end of ten days to two weeks; it is almost nil and in a short time after they are home it is absolutely nil. That looks like a very decent record. On the other hand, if you treat them without instrumental curettage, ninety-six per cent of them will leave the hospital well or at least alive, but the discharge may continue. If you use this conservative method with the patient she may become rather disgruntled and come back with, "Doctor, I am sorry, but I still have some of that nasty, foul, chocolate discharge," and she may seek advice elsewhere after you have got her past the critical point.

It is infection that we dread, and Gellhorn and others make the point that except for the urgency necessitated by hemorrhage, infection is the point to watch after all. Explain to your patient that if you curette, ninety-two out of a hundred will go out well, and if you don't curette, ninety-six will leave the hospital alive. Now, as between ninety-two and ninety-six there is not much difference, but looking at the thing from the standpoint of mortality, if you curette, it is eight per cent, and if you don't, it is four per cent, and you have no right to ask any patient to undergo a procedure that doubles her chance of death.

DR. G. METZLER, JR.: From what I get from authorities on the cases of syphilis causing abortions, most of them seem to agree that it was more in the later months that pregnancy was interrupted due to lues rather than in the early months and that more cases of premature labor occur due to lues rather than abortion in the early months.

Prenatal Treatment of Syphilis

Udo J. Wile and Joseph W. Shaw, Ann Arbor, Mich. (*Journal A. M. A.*, Dec. 13, 1930), studied 100 cases of pregnancy complicated by syphilis in which careful physical examination revealed the patients otherwise in good health. The personnel of this group is made up largely of young girls, the average age being 19.7 years, 65 per cent of whom were unmarried. In this group the average age of the infection at the time of examination was 13.8 months. Apparently 35 per cent contracted their infection at the time of conception, there being a history of but one exposure; 16 per cent contracted their infection two to three months before conception and 5 per cent two to three months after conception, giving a total of fifty-five cases, or 55 per cent, in which infection occurred at or shortly after the time of conception. They observed early active clinical syphilis in forty-two patients of the series, one presenting a primary sore, one presenting a primary with secondary manifestations, and forty with florid secondaries. Lumbar puncture was done on all patients when seen in the early months of pregnancy. The spinal fluid of 64 patients was examined, and of these, 51, or 79.7 per cent, were entirely negative; 6, or 9.4 per cent, were strongly positive (by Wassermann or Kahn tests) and showed characteristic changes in cells, solids and the colloidal gold curve; 4, or 6.2 per cent, were weakly positive, and 3, or 4.7 per cent, showed an increase in cells and solids with no other observations. Of the 13 cases showing laboratory evidence of cerebro-spinal involvement or invasion, only 2 showed clinical evidence of syphilitic central nervous system disease. Treatment was instituted in the form of intravenous arsphenamine, followed by mercury inunction, immediately on recognition of the disease. The average time for beginning treatment was about the nineteenth to the twentieth week of pregnancy. Each patient had a complete physical examination and urine analysis. If there were no contra-indications, the patients were hospitalized and kept under careful observation following each injection. Most of the series (82 per cent) received arsphenamine; the remaining 18 per cent received neoarsphenamine. Courses were given with from three to six injections in a course and an interval of from one to three months allowed between courses, during which time mercury was administered in the form of inunctions. The patients averaged 2.2 Gm. of arsphenamine. Some re-

ceived as much as 4 Gm. of arsphenamine during pregnancy, and none showed untoward effects as a result. The average amount of mercury for the group was a course of thirty-five inunctions. No reaction of any import that could be attributed was observed. There were delivered from the 100 syphilitic women 92 living babies, of whom 7 were premature and 85 were full term. Of the remaining 8, 3 were premature stillbirths, 2 were full term stillbirths, and 3 were born prematurely but lived only a few hours. Of the 8 ending disastrously, all showed evidence of syphilis at the autopsy table. Six of the latter group were the products of apparent conceptional syphilis. The Wassermann or Kahn tests were done on the cord blood of the 92 living children. Forty-four were reported as strongly positive, 17 as weakly positive and 31, or 33.7 per cent, as negative. Twenty-six of the 92 living infants apparently had escaped infection, while 66 fell in the group which should have immediate antisymphilitic therapy. Treatment was instituted in these 66 cases within the first two weeks of life. This consisted of six weekly intravenous injections of neoarsphenamine. (Those in whom venipuncture could not be done received six intramuscular sulpharsphenamine injections at weekly intervals.) They were all observed over a period of time from seven to eight weeks following birth, during which time they were found to tolerate the drug, and they gained weight well within normal limits. Following the sixth injection, the infants were discharged with either mercury with shalk, to be taken by mouth, or mercury in the form of inunctions. The untreated or apparently nonsymphilitic group were observed for a variable period of from four to eight weeks. If nothing developed at the end of this time, they were discharged and the mother was instructed to report to the authors or to her home physician at the end of three months for observations and repeat serologic examinations. Of the ninety-two living births, two of those alleged to be nonsymphilitic developed acute syphilis and died within the first three months of life. Of the treated group, three died within the first year, two of pneumonia and one of syphilis; one died the second year and one the third year, cause unknown, while another died the third year of pneumonia. Seventy-one of these children were living and in apparently good health, from one to five years after birth. Thirteen could not be located. So that of the seventy-nine infants traced, 89.9 per cent were living from one to five years afterward.

EDITORIAL

DELAWARE STATE MEDICAL JOURNAL

Owned and published by the Medical Society of Delaware. Issued about the twentieth of each month under the supervision of the Publication Committee.

W. EDWIN BIRD, M. D. EDITOR
DuPont Building, Wilmington, Del.

W. OSCAR LAMOTTE, M. D. Associate Editor
Medical Arts Building, Wilmington, Del.

M. A. TARUMIANZ, M. D. Associate Editor & Bus. Mgr.
DuPont Building, Wilmington, Del.
Telephone, Wilmington, 4368

Articles sent this Journal for publication and all those read at the annual meetings of the State Society are the sole property of this Journal. The Journal relies on each individual contributor's strict adherence to this well-known rule of medical journalism. In the event an article sent this Journal for publication is published before appearance in the Journal, the manuscript will be returned to the writer.

Manuscript should be sent in typewritten, double spaced, wide margin, one side only. Manuscript will not be returned unless return postage is forwarded.

The right is reserved to reject material submitted for either editorial or advertising columns. The Publication Committee does not hold itself responsible for views expressed either in editorials or other articles when signed by the author.

Reprints of original articles will be supplied at actual cost, provided requests for them is attached to manuscripts or made in sufficient time before publication.

All correspondence regarding editorial matters, articles, book reviews, etc., should be addressed to the Editor. All correspondence regarding advertisements, rates, etc., should be addressed to the Business Manager.

Local news of possible interest to the medical profession, notes on removals, changes in address, births, deaths and weddings will be gratefully received.

All advertisements are received subject to the approval of the Council on Pharmacy and Chemistry of the American Medical Association.

It is suggested that wherever possible members of the State Society should patronize our advertisers in preference to others as a matter of fair reciprocity.

Subscription price: \$2.00 per annum in advance. Single copies, 20 cents. Foreign countries: \$2.50 per annum.

Vol. III

JANUARY, 1931.

No. 1

GREETINGS

As President of the Medical Society of Delaware it gives me the greatest pleasure to extend my most sincere best wishes to the members for the happiest and most prosperous year that you have ever known.

In the years that I have been associated with this Society I feel that it has made great strides, gradually becoming a bigger and better one, and I hope that each and every one will continue to make even greater efforts to make our Medical Society one of the outstanding ones in the country. I feel that if we all co-operate this can be accomplished. Delaware has always been one of the very first states in all the affairs of our country, and I feel it is not too much to expect our Medical Society to follow suit. After all, we physicians are really the ones who hold the welfare of our state in our

hands. If our citizens do not have the proper medical care, and are not healthy both in body and mind, they naturally cannot give their best to their work, whether they hold offices, make the laws, or carry out and respect the laws after they are made. Every one of us, rich or poor, has to depend entirely upon our health to perform all our duties. Then is it not up to the men and women who have spent years of study to be able to treat intelligently, to give every ounce of our strength and knowledge to help those who make up our communities and state? To teach and educate the people what is best for them can not be done by one, or even several persons; we must have the co-operation of all.

I feel that the greatest factors in the success of any organization such as ours are real fraternity and genuine tolerance among our members. I plan to attend some of the county medical society meetings during this year, and come in closer contact with every one in each. Our State Society is really made up of three parts, and if these three work together and make one grand whole, there is no reason why we should not accomplish great things, in even such a short time as one year. I hope and trust that every member will do his bit towards making this year the greatest of all, and to continue so, on down through the coming years. The meeting in October is really the criterion by which we judge whether we have progressed any over the years before, and I wish every member to feel that he is responsible for this success. Any suggestions and comments that will be helpful in fulfilling our hopes in this respect will be appreciated.

Our Society is one that any man should be glad to belong to. The type and calibre of the men cannot be excelled in any state society, however large that society may be. I am proud that such men have deemed me fit to hold the highest honor that they can bestow, and I hope that I may be worthy of the great confidence you have placed in me.

GEORGE C. McELPATRICK, M. D.

NEW PSYCHIATRIC OBSERVATION CLINIC

The Psychiatric Observation Clinic of the State of Delaware will be opened by the first of February. Other states have observation clinics in which patients who are suffering from mental

and nervous diseases are studied and diagnosed before being committed to a state hospital, but Delaware is one of the few states which has a period of observation for all before they are regularly committed. It is fortunate that our state is small in area as well as in population, for only in such a situation can so comprehensive a plan be carried out. It is possible to produce an ideal situation under such favorable circumstances.

A clinic which studies all types of mental and nervous diseases as well as those actually psychotic before commitment is a valued addition to any state institution. In many instances actual residence in a hospital for mental diseases may be avoided. This would be particularly true of patients suffering from certain types of toxic psychoses, mild depression, etc.

The institution to be opened has facilities for forty patients—twenty male and twenty female. It is a complete hospital unit in itself, being fully equipped for all types of diagnoses and treatment. Among other factors there will be a portable xray unit, an individual dental unit, physio- and hydro-therapy, etc.

To be insane is still considered a disgrace, and it will still take much effort on the part of the physicians to change such an idea. The present status of mental and nervous diseases must be changed so that the feeling towards those so afflicted will be that of any person physically ill. The medical profession of the state should realize the importance of such an institution, and readily use the advantages which are offered. To have such advantages is an opportunity not had by many whose efficiency is lowered by borderline mental or nervous defects, many of which defects can readily be alleviated by a short period of study and treatment.

The medical profession should do its part in educating the public to recognize the early signs of nervous troubles so that serious results can be avoided. They should not feel that contact with mental diseases is abhorrent, but they should take the same interest in such cases as in other bodily diseases. When it is realized that one out of every twenty-five people will at some time suffer from some serious mental or nervous disease, warranting special care and treatment, the importance of such a clinic can readily be realized.

For the benefit of those who are interested we are printing the rules for admission to this clinic on page 14 of this issue.

EDITORIAL NOTES

DEAR DOCTOR:

THE JOURNAL and the Cooperative Medical Advertising Bureau of Chicago maintain a Service Department to answer inquiries from you about pharmaceuticals, surgical instruments and other manufactured products, such as soaps, clothing, automobiles, etc., which you may need in your home, office, sanitarium or hospital.

We invite and urge you to use this Service.

It is absolutely free to you.

The Cooperative Bureau is equipped with catalogues and price list of manufacturers, and can supply you information by return mail.

Perhaps you want a certain kind of instrument which is not advertised in THE JOURNAL, and do not know where to secure it; or do not know where to obtain some automobile supplies you need. This Service Bureau will give you the information.

Whenever possible, the goods will be advertised in our pages but if they are not, we urge you to ask THE JOURNAL about them, or write direct to the Cooperative Medical Advertising Bureau, 535 N. Dearborn St., Chicago, Illinois.

We want: THE JOURNAL to serve you.

The times must surely be out of joint, otherwise such a circular as is reproduced below would have no occasion for its being. Only pathos can be read between its lines. Let us hope and work for the removal of the conditions that call it forth. Here it is:

Dear Doctor: Can you use an ASSISTANT? We have available—

YOUNG SURGEONS: (A) BS MD Northwestern age 33, single; 2 years internship New Orleans Charity Hospital; Texas license. (B) BS MD University of Virginia age 28, single; 2 years internship, 526-bed hospital. National Board licentiate; \$300, south. (C) BS MD Mississippi University age 30, single; wants dry climate. Has done 337 majors, 225 assists, 250 deliveries. Will take surgical residency or assistantship.

INDUSTRIAL SURGEONS: (A) Canadian MD McGill age 32, single; 1 year internship, 1 year surgical intern, Montreal General Hospital. \$300. (B) MD Toronto age 26, Pennsylvania license; 1 year internship; Chief Resident 200-bed hospital with active industrial service. \$250-\$300.

NEURO-SURGEON: BS MD Nebraska age 33, married; 1 year internship; 3 years practice; 2 years Mayo Fellow, Neurosurgery; 1 year Chief Neurosurgeon, 300-bed hospital. Wants southwest, \$7,000.

EXPERIENCED SURGEONS: (A) BS MD Colorado age 39; 3 years industrial surgery; 10 years general practice; 2 years post-graduate Orthopedic surgery; Surgery and Gynecology, Chicago, Baltimore, New York, Rochester, Minn. Wants Northwest or New York. \$3,600. (B) MD Nebraska age 35; 21 months internship; 3 years industrial work; experienced in lead poisoning research and pneumoconiosis, industrial surgery. Licensed California. \$350.

SURGEON-ROENTGENOLOGIST: MD University of Manitoba age 32; 3 years surgical Assistant; 2 years major surgeon-roentgenologist and hospital executive, southern clinic. \$300.

SURGEON-UROLOGIST: AB MD Washington University, St. Louis; age 27, single. 1 year internship 650-bed hospital; 1 year each Assistant Resident and Resident in Urology, 300-bed University hospital; National Board license; wants midwest or California. \$200.

There is much in favor of the following editorial from the *Southern Medical Journal*, which objects to certain of the colorless names now being attached to many medicinals. In the present case the objection to substituting iopax for uroselectan seems justified, as follows:

WHAT IS IOPAX?

The JOURNAL has already commented upon the addition to the diagnostic tools of radiology and urology of a dye, called by its German sponsors uroselectan. Uroselectan is a radiopaque combination of iodine and a pyridine derivative, which after intravenous injection is excreted through the kidneys. It causes little systemic reaction, and with its aid very fine visualization of the kidneys and urinary tract may at times be obtained. It is useful also in retrograde pyelography, since it is less irritating to the tissues than the iodides formerly used for filling the kidney pelvis from below. It has been rather favorably reported on in the past few months. Its main drawback would seem to be the very high price, six dollars plus, for a single dose.

The Council on Pharmacy and Chemistry of the American Medical Association has reported on it and is in process of giving it a legal christening with which will go a new name. "Since this name (uroselectan) was tantamount to a therapeutic suggestion," says the Council's report, "the Council recommended its replacement by an acceptable designation, and accordingly the distributor is considering the adoption of the name Iopax, which the Council finds acceptable."

May the SOUTHERN MEDICAL JOURNAL herein register a feeble protest? The JOURNAL always likes to follow the Council's suggestions and heartily endorses and profoundly admires its great work. It feels that the neutralization and codification of scientific nomenclature should be limited to curative or healing drugs. Man's passion for therapeutic adventure alone needs to be checked. No therapeutic use is claimed for uroselectan, as would be if an anti-syphilitic drug were designated "luetin", or a urinary antiseptic "pyelitin". Uroselectan is an instrument of diagnosis. The name cystoscope might as easily be said to contain a therapeutic suggestion.

Free play of scientific imagination in the diagnostic branches of medicine and in the ancillary medical sciences such as physiology, anatomy, bacteriology, and histology, always does much more good than harm. In these subjects, names with a vivid connotation should be encouraged, names which contain the history of important theories.

Progress is a series of mistakes. There is the well-known tale of the three classes of persons who never make them: The oyster, because he never does anything; the liar, because he never admits an error; and the fool, because he is never aware that he has erred. Mistakes of theory are to be expected among scientific workers, and are always stimulating to research.

What does it matter whether the bacteriophage eats bacteria or is incapable of assimilation in a heterogeneous medium? The term bacteriophage, with D'Herelle's entire hypothesis implied in a few syllables, did more within ten years to stimulate in-

vestigation into the nature of bacteriophagic phenomena, did more to advance the science of bacteriology, than Twort's uncrystallized observations or the appellation "lytic principle" could have done in thirty.

The name "vitamine" popularized and advanced the knowledge of these active elements of nutrition as the term "accessory food factor" never could.

The name should be retained which tells a story. Words are treasures when they recapitulate the history of a controversy. A drug or scientific idea upon official recognition should not be robbed of its background and historic significance.

Uroselectan is a name which has been used through a large number of pioneer experiments and reports. It has a distinctive meaning. It tells a story and embodies an idea. Iopax is a colorless and lifeless arrangement of five letters of the alphabet, to be confused with iodox, iodeikon, iodipin, ideol, allanol, and forty others. For the future of medical history and the student, for the pharmacist and the practitioner, picturesque names should not by legal enactment be erased from scientific literature.

We sometimes wonder what the cigarette people are going to pull off next. One brand suffocates us with its "20,679 physicians said" something or other, and burns us up with its "violet-ray" treatment. Now a competitor, reaching for something really bizarre, insults our intelligence by resurrecting the *science of numerology*. Ye gods! Said alleged science of numerology died a natural death at the birth of the Renaissance, in the fifteenth century, along with palmistry, and fortune-telling by cards. And lo! this hokum is dished up to us, in this year of grace 1931, by the omnipotent radio, for the edification of that intellectually submerged tenth that still believes this world is flat, and who insist the sun revolves around the earth. Yea, verily, it is a treat to tune in on WOR or WFAN on Tuesday at 9 P. M., and learn how "names and dates effect success in business, love or marriage. A real radio thrill." Believe it or not, she'll tell you how. But then—you can always turn the dial and pick up something not quite so nauseating.

The Wilmington section of the American College of Surgeons is slowly making accessions, the latest being Dr. Walter L. Liefeld, late of Passaic, N. J., who has engaged here in the practice of oto-laryngology. The list of Fellows now is: Drs. Bird, LaMotte, Liefeld, Mayerberg, Mullin, Parsons, Pierson, Spackman, Speer, Springer, Veasey, Wertenbaker, and White. There are several others who now are, or soon will be, eligible.

DELAWARE PHARMACEUTICAL SOCIETY

NARCOTIC ENFORCEMENT

Commissioner of Narcotics Harry J. Anslinger and his legal and administrative assistants are preparing regulations for the enforcement of that provision of the Porter Act directing the Secretary of the Treasury to co-operate with the states in the enforcement of their narcotic laws. The executive and legal representatives of the N. A. R. D. have carefully considered this particular provision of the new law and volunteered information and advice to the Commissioner because, as counsel for the department interprets the Porter Act, provision must be made in the regulations for co-operation between the federal government and state boards of pharmacy as well as state boards of health. When the Porter bill was pending before the Ways and Means Committee of the House the only question raised was in relation to the addiction of physicians to habit-forming narcotic drugs and legal measures to check it. Representatives of the American Medical Association testified that state boards of health could do this if the federal government would furnish whatever evidence it had. Federal attorneys hold that the new law applies to druggists as well as to physicians in this respect. The N. A. R. D. takes the position that if the federal government furnishes evidence in its possession to state boards of health and state boards of pharmacy it should be limited to cases of narcotic drug addiction. If the federal government furnished state boards with the record in every case the penalty of which was compromised on behalf of a retail druggist serious trouble and expense would result, which would not be warranted by the technical and trivial nature of the offense.

STATE NARCOTIC LAWS

The representatives of the N. A. R. D. are receiving requests from officers of state and local pharmaceutical associations for information and advice concerning bills to be introduced in some of the legislatures convening in January changing certain state narcotic laws. In every case it will be necessary to furnish a copy of the bill to be introduced and to allow the representatives of the N. A. R. D. sufficient time to analyze all of the provisions of each bill and prepare pertinent and appropriate comment. A joint committee representing the American Medical Association and the American Bar Association has

prepared what is known as the fourth tentative draft of a proposed uniform state narcotic act, which in some, if not many, instances, may be used as the basis for bills that will be introduced at the coming sessions of the legislatures. The representatives of the N. A. R. D. have had this draft under consideration for some time and have prepared necessary amendments. Action by the American Bar Association has been postponed until its next annual convention, but it would seem that certain over-zealous advocates of state narcotic legislation are not disposed to await the action of the American Bar Association and the American Medical Association. In the interest of uniform as well as safe and sane legislation, state and local pharmaceutical associations should discourage tinkering with their state narcotic laws until the time has arrived when this may be done intelligently and with due regard for the legal rights and obligations of druggists and doctors as well as the public welfare.—*N. A. R. D. Journal.*

WOMAN'S AUXILIARY

Panoramic View of the Woman's Auxiliary

1. The Eastern District

MRS. W. WAYNE BABCOCK

PHILADELPHIA, PA.

According to the Constitution of the National Auxiliary the first vice-president is automatically chairman of organization, the three other vice-presidents being organizers for their section of the country. Mrs. Southgate Leigh of Virginia, therefore, holds this chairmanship, and the Eastern District is her particular responsibility. At her request a series of four articles is being prepared by her committee in order that each district may be cognizant of the progress of its own state as well as those of the other three sections. The individual state journals have been generous in extreme in the space they have allowed their auxiliaries and this additional courtesy of reporting the auxiliary situation in other states is deeply appreciated, for there is a growing desire to know "what others are doing."

New Hampshire stands alone as the only New England State 100% organized and co-operating with the National Organization. Last year the state auxiliary had misgivings as to its necessity and usefulness but an urgent request from the medical society that the women remain organized, dispelled all doubts. During the year fol-

lowing, Mrs. Hubbard, wife of the state president, visited every county which encouraged and stimulated the growth of unit auxiliaries.

The New Jersey Auxiliary made pilgrimages to state institutions, set apart one meeting when the mothers of physicians were entertained, and sponsored various health meetings. The Essex County Auxiliary, assisted by the physicians, succeeded in establishing a course of health talks, in co-operation with the Y. W. C. A. of Newark, emphasizing especially pre-natal care and information which would aid the mothers of babies and young children. Last year Mrs. James Hunter, Jr., New Jersey's state president, visited every county as did Mrs. Walter Jackson Freeman in Pennsylvania, during her presidency. One cannot help drawing the conclusion that personal contacts are necessary for county development and success.

Virginia is active in spots. The doctors encourage the auxiliaries as they believe that through them education with regard to the menace of state medicine can be spread.

Ohio for several years has been sending representatives from a few organized counties to the national meetings but as yet there is no state organization. As our friend and advisor, Dr. Upham, lives in Ohio, it is felt that he will advise the National Auxiliary when the auspicious time arrives for the establishment of a state auxiliary.

The District of Columbia seems so completely diverted with Washington affairs that the auxiliary which so capably cared for the A. M. A. meetings some years back seems to have gone into retirement.

Delaware in a breathless, better-late-than-never manner, has completely caught up and is most interested and active and has entered upon serious work by assisting the men of the profession in establishing a medical library in Wilmington. They will co-operate with Philadelphia at the time of A. M. A. and the eastern section will introduce them with pride to the National Organization. West Virginia is up and doing and you may expect still better things from that State this year.

Maine, Massachusetts, Rhode Island, Vermont and Maryland have reported the interest of individuals but no organized effort. Queries from different localities in New York as to why there is no auxiliary have been answered with the

statement that several years ago the House of Delegates voted unanimously in favor of the auxiliary and authorized its organization. The same year Connecticut voted favorably but no definite steps have been taken.

Pennsylvania has surely discovered the rhythm in which its auxiliary work is best done, for concrete accomplishments have been turned out regularly, year by year. Of the three thousand dollars contributed last year to the Medical Benevolence Fund more than two-thirds was contributed by the Auxiliary. A definite trend toward educational meetings is felt all over the state and socially it is hoped that the carefully formed Philadelphia plans for the next meeting will bring honor and glory to the Keystone State. Not only are the adult members of the auxiliary meeting but a group of the most charming and good-looking daughters of doctors are working together in order that they may know each other and work in unison for the comfort and pleasure of the A. M. A. guests when they come to Philadelphia in May. Verily, who can question the wisdom of the auxiliary, when it brings about so much willing work in behalf of the medical men of the country?

Delaware Doings

The Woman's Auxiliary to the Medical Society of Delaware is evincing much eagerness to co-operate with the Medical Society for the amendment to the Klair Law.

We have accepted an invitation to become a member of the Women's Joint Legislative Committee which meets at Dover every Monday during the session of the Legislature. The four delegates to the committee are: Mrs. Robert Tomlinson and Mrs. Edgar Bullock, of Wilmington; Mrs. Joseph McDaniel, of Dover; and Mrs. Richard Beebe, of Lewes. The alternates are: Mrs. Lawrence Jones and Mrs. James France, of Wilmington; Mrs. Calvin Ogburn, of Dover; and Mrs. J. D. Niles, of Townsend.

The Woman's Auxiliary has also affiliated with the City Federation and Mrs. Tomlinson has been put on their Legislative Committee. The following are the delegates and alternates to the City Federation: Delegates, Mrs. Robert Tomlinson, Mrs. Raymond Moore, Mrs. H. G. Buckmaster, Mrs. E. R. Mayerberg; alternates, Mrs. E. H. Lenderman, Mrs. Price, Mrs. P. A. M. Rovitti, and Mrs. H. R. Spruance.

Meanwhile the women of Philadelphia are

working energetically on plans for the national Auxiliary convention, concurrent with the American Medical Association convention in June. The Delaware Auxiliary has been asked to help and is represented on various committees.

The Executive Committee is as follows: Mrs. Walter Jackson Freeman, general chairman; Mrs. Wilmer Krusen, secretary; Mrs. Robert Tomlinson, treasurer; Mrs. J. Newton Hunsberger, national president ex officio; Mrs. Alfred Stengle, Mrs. James Hunter, Mrs. W. B. Odenotte.

The following are committees composed of all Wilmington members: Music Committee, Mrs. Paul Smith, Mrs. John H. Mullin; Bellevue Menus, Mrs. Harold Springer, Mrs. George McElfatrick; Finance Committee, Mrs. W. O. LaMotte; County Committee, Mrs. Willard Smith, Mrs. Joseph McDaniel, Mrs. W. P. Orr.

MISCELLANEOUS

New Castle County Election

Election of officers for 1931 took place on December 16, 1930. The results were as follows:

President, Dr. J. D. Niles. Vice-President, Dr. George W. Vaughan. Secretary, Dr. D. T. Davidson. Treasurer, Dr. Louis S. Parsons. Delegates, Doctors J. Adair, W. E. Bird, L. Booker, I. L. Chipman, W. W. Ellis, G. W. K. Forrest, D. W. Lewis, W. V. Marshall, L. S. Parsons, H. L. Springer, P. W. Tomlinson, J. P. Wales. Alternates, Doctors O. S. Allen, L. H. Ball, J. M. Barsky, J. W. Butler, D. T. Davidson, T. H. Davies, C. M. Hanby, L. J. Jones, E. R. Mayerberg, M. I. Samuel, B. S. Vallett. Director, Dr. R. W. Tomlinson. Censor, Dr. C. P. White.

Medical Society of Sussex County

The Medical Society of Sussex County at their meeting in Georgetown elected the following officers for 1931:

President, Dr. Kendall Hocker, Millville.

Vice-President, Dr. William P. Orr, Lewes.

Secretary and Treasurer, Dr. Ernest F. Smith, Georgetown.

For the program, Dr. Clyde Nelson, Milford, was the principal speaker. He presented for the dental profession the need of a corps of oral hygienists in the State of Delaware. In conjunction with the State Board of Health and Board of Education, dental nurses would aim to lessen the prevalence of mouth infections and poor teeth in school children. There is to be a consideration

of this problem during sessions of the Legislature. The Medical Society went on record as endorsing this work.

At the conclusion of the luncheon, Dr. Nelson gave a lantern slide demonstration of his work with members of the Byrd Expedition in New York and aboard the "City of New York" returning from Panama. Unusual camera pictures of the Polar flight followed the scientific presentation.

PSYCHIATRIC OBSERVATION CLINIC

Rules for Admission of Patients

As prescribed by law, the State Board of Trustees has established a Psychiatric Observation Clinic for observation, study, diagnosis and treatment of acute and sub-acute psychotic, neurotic, and doubtful mental and nervous cases.

The building accommodates twenty men and twenty women. At the present time there are no beds available for colored patients.

Any physician licensed to practice medicine within this State may cause any patient under his care or treatment, who is suffering from an acute, sub-acute or doubtful mental or nervous disease, to be admitted to the said Clinic, provided the said physician will make an application (on official blanks) for the admission of such a patient, and provided the said physician reports the case to the member of the Board of Trustees of the Delaware State Hospital of the district in which the patient resides; after complying with this, the said physician shall communicate (by telephone or otherwise) with the Superintendent of the Delaware State Hospital, and if there is an available bed in the Clinic, the Superintendent makes arrangements to admit such patient; if not, the application is placed on file and the attending physician is notified when a vacancy occurs.

A patient admitted to the Psychiatric Observation Clinic shall remain in said Clinic for a period not to exceed four weeks; but if the said Clinic, after observation and study of the case, finds that the case does not require any further hospitalization in the said Clinic, it has the authority to discharge such case after notifying the attending physician and the family of the patient.

On the other hand, if the said Clinic finds necessary to prolong the hospitalization of the patient for a further period of four weeks duration, such patient may be detained in the Clinic for this period, upon the approval of the State Board of Trustees. Any person who shall be admitted into the said Clinic shall not be allowed to depart therefrom prior to the expiration of such four weeks period or any extension thereof, in case such extension shall have been made, without the consent of the Superintendent of the Delaware State Hospital.

If a patient admitted to the said Clinic for Observation is found suffering from a psychosis, which requires prolonged hospitalization, such case must be reported to the State Board of Trustees of the Delaware State Hospital by the Superintendent. Upon such report the State Board of Trustees shall appoint a commission consisting of two qualified and licensed physicians, who shall determine whether the said case is insane and should be legally committed to the Delaware State Hospital. Should the relatives of the patient so desire, a jury of six responsible persons shall be impaneled by the said State Board of Trustees. The said jury or said commission, as the case may be, shall report their findings to the said State Board of Trustees, and if the report shall be that

such person is suffering from definite psychosis and should be committed into said State Hospital, such a report shall be sufficient for the commitment of such person, subject to the right of appeal provided in the statutes.

According to the Chapter 243, Section 6, patients committed to the Delaware State Hospital with a certificate signed by two physicians, (who have been actively engaged in the practice of medicine for at least five years, and who are residents of the same State and County as the patient), shall be observed and studied for a period of time not to exceed four weeks or any extension thereof, in case such extension shall have been made with the consent of the State Board of Trustees of the Delaware State Hospital, and if the report of the hospital shall be, that the said insane person must be legally committed to the State Hospital, because of definite psychosis, the State Board of Trustees shall appoint a commission consisting of two qualified and licensed physicians of this State, who shall determine whether such supposed insane person should be committed to the State Hospital.

Should the relatives of the patient so desire, a jury of six responsible persons shall be impaneled by the said State Board of Trustees. The said jury or the said commission, as the case may be, shall report their findings to the said State Board of Trustees, and if the report shall be that such person is suffering from definite psychosis and should be committed into the State Hospital, such a report shall be sufficient for the commitment of such person, subject to the right of appeal provided in the statutes.

Approved: THE STATE BOARD OF TRUSTEES
OF THE DELAWARE STATE HOSPITAL.

January 8, 1931.

Coroner's Notice

Kindly be advised that on and after 10 A. M., Tuesday, January 6, 1931, the Coroner's Office will be maintained at 1402 North Market Street, under the supervision of Deputy Coroner H. Herbert Hirzel.

It is my desire to work in harmony with all hospitals, physicians, members of the Department of Public Safety and all public officials, as well as render an efficient and faithful service to the general public.

All cases under the jurisdiction of this office should be reported immediately by calling phones numbers 9855, which is the Morgue and parlors of H. Herbert Hirzel, and 2-7913, being the residence of the Deputy Coroner.

My own personal phone is New Castle 444.

Trusting that we will have pleasant relations in the future, and wishing you a Happy New Year, I am

Sincerely yours,

HARRY P. AHERN,
Coroner.

New Cancer Journal

In an endeavor to make available all of the world's literature pertaining to cancer, The Chem-

ical Foundation is collaborating with The American Association for Cancer Research and The American Society for the Control of Cancer in the publication of "The American Journal of Cancer," the first issue of which will appear on January 1, 1931, and will replace The Journal of Cancer Research. It will contain articles, reviews, and abstracts covering every phase of cancer, including pathology, gynecology, dermatology, urology, neurology, surgery, chemistry, biology, and genetics.

In order to completely cover the field, The Foundation is also co-operating with The Radiological Society of North America in enlarging its official publication, "Radiology," to include all uses of radiant energy in the diagnosis and treatment of cancer with articles, reviews, and abstracts on radium and xray from the viewpoint of the radiologist, physicist, physiologist, diagnostician, and research worker.

These publications will keep physicians abreast of the progress being made in the diagnosis and treatment of cancer.

The Central Bureau for the Study of Tumors

This Bureau, organized and conducted by Dr. Joseph McFarland, Professor of Pathology in the University of Pennsylvania, at present occupies a large and comfortable room in a small building on the grounds of the Lankenau Hospital, Philadelphia, through the interest and generosity of the trustees of that institution.

The Bureau has a membership composed of the pathologists of about forty of the hospitals of Philadelphia and vicinity, and is controlled by an Executive Committee consisting of Dr. Virgil H. Moon, Professor of Pathology in the Jefferson Medical College, Dr. John I. Fanz, Professor of Pathology in the Temple University, Dr. Helen Ingleby, Professor of Pathology in the Woman's Medical College of Pennsylvania, Dr. Eugene A. Case, Professor of Pathology in the Graduate School of Medicine of the University of Pennsylvania, Dr. Stanley P. Reiman of the Research Institute of the Lankenau Hospital, Dr. John Eiman, Pathologist to the Presbyterian Hospital, and Dr. Damon Pfeiffer of the American Association for the Control of Cancer. These names should be sufficient to give it excellent scientific standing, and the various institutions with which

they are connected, to show its independence and freedom from institutional jealousy.

The Bureau at present obtains from its members, material and mounted slides from all of the tumors operated upon in all of their hospitals, with as much data concerning each as is available. More than one thousand specimens and data are filed, classified and indexed so as to be available to any who desire to study them, and the ever increasing number of unusual tumors will, in time, make the collection invaluable for the identification of other unusual tumors by comparison, for instead of being distributed in small numbers among many institutions, they will be collected in this one Central Bureau.

The Bureau is not a diagnostic agency. The diagnosis of tumors for surgeons and others is the prerogative of the pathologists of the hospitals with which they are connected, and the privilege of consultations about tumors and tumor sections is reserved for the members.

The Bureau also carefully follows up all of its cases for the purpose of determining the complete history of each, in order that better diagnosis and prognosis may be possible in the future, for the purpose of calling the patients' attention to the fact that they must be attentive to themselves, and for the eventual purpose of learning how frequently cures are effected and life prolonged by treatment.

The names of the patients and the details of treatment are kept strictly confidential. In return for data furnished by the surgeons and physicians, the Bureau notifies them of any new facts about them that it may obtain by correspondence or visitation.

Although the Director insists that the Bureau can make no scientific contribution of value until its work has continued for at least five years, some good results seem to have arrived already. Among these may be mentioned the improvement in technical work in the hospital laboratories. This is partly due to a proper desire to deposit only good sections in the Bureau, to a tactful criticism of bad technical work when it has appeared, and a willingness on the part of the Bureau to give gratuitous instruction to technicians when it is desired.

Some embarrassment resulting from the inability of the hospitals to furnish the data asked for, may be resulting in better case histories being taken and better records kept by the hospitals,

and the emphasis laid on the follow-up of cases has resulted in at least one institution establishing a follow-up system where none existed before.

The Director gives his services gratuitously, the Bureau has limited financial resources, is run with great economy, and is a worthy object to which to contribute money.

American Board of Obstetrics and Gynecology

The American Board of Obstetrics and Gynecology, composed of nine members and examiners, elected by The American Association of Obstetricians, Gynecologists, and Abdominal Surgeons, The American Gynecological Society, and the Section on Obstetrics, Gynecology, and Abdominal Surgery of The American Medical Association, was formally organized in Niagara Falls, September 16, 1930. The function of the Board is to grant certificates indicating proficiency and specialization in Obstetrics or Gynecology, or both, to those who comply with its requirements.

The nine members of the Board are:

Dr. Walter T. Dannreuther, New York City.

Dr. Fred L. Adair, Chicago.

Dr. E. A. Schumann, Philadelphia.

Dr. Paul Titus, Pittsburgh, Secretary-Treasurer.

Dr. Joseph L. Baer, Chicago.

Dr. Jennings C. Litzberg, Minneapolis.

Dr. Robert D. Mussey, Rochester, Minn.

Dr. E. D. Plass, Iowa City, Iowa.

Dr. G. D. Royston, St. Louis.

This Board has been in the process of organization since 1927. It puts into action a determined effort on the part of these three national organizations to improve the standards of practice of obstetrics and gynecology. It expects to accomplish this by various activities, such as the investigation and encouragement of graduate extension study facilities and active clinical assistantships for men desiring to specialize in these branches, and it will endeavor by regular examinations to determine the competence of specialists in obstetrics and gynecology who apply for the certificate. *Group 1*—Certain outstanding specialists will be granted certificates on the basis of their attainments alone, but only by a vote of the entire Board after recommendation by the Committee on Requirements. *Group 2*—A second group is asked to undergo a practical clinical examination. *Group 3*—A younger group has both written and clinical examination, and must submit records of a group of cases in order to qualify.

The national obstetrical and gynecological organizations, which have participated in the formation of the Board and are sponsoring its activities, as well as other societies, attach considerable importance to its Certificate. It is expected that both the medical and the lay public, including hospital directors, will soon come to utilize the certificate from this Board as a means of discriminating between those who are well-grounded as specialists in obstetrics and gynecology, and those who are not.

The Board does not intend in any way to interfere with or limit the professional activities of any duly licensed physician, but it does aim toward standardized qualifications for specialists in obstetrics and gynecology.

Any well-qualified obstetrician and gynecologist should have no difficulty in obtaining a certificate and

the Board is desirous of receiving applications from those to whom this applies.

The first written examination for candidates in Group 3 will be held simultaneously in nineteen different cities of this country, including Philadelphia and Baltimore, and Canada on Saturday, March 14, 1931.

The written examination must be taken by all applicants classified in Group 3.

The examination will consist of ten questions on obstetrics and gynecology, and a minimum rating of 75 per cent will be required. Each candidate for Group 3 will also be required to submit typewritten reports on a total of fifty (50) obstetrical and gynecological operations which he has performed, and these case records are to be presented with his examination paper to his local examiner on March 14th.

The practice, or oral, clinical, and laboratory examination will be held in Philadelphia, Pa., on Saturday, June 6th, 1931, commencing at 9 A. M. and will be given to all applicants in Group 2 and Group 3. The candidates will be expected to identify and discuss three or four common obstetrical and gynecological pathologic specimens and the histologic sections taken from them. The clinical part of the examination will be conducted in a hospital where an individual case will be discussed in detail with each candidate. An endeavor will be made to adapt the details of the oral examination to each candidate's experience and practice, and will be particularly directed to ascertain his familiarity with recent obstetrical and gynecological literature, the breadth of his clinical experience, and his general qualifications as a specialist in Obstetrics and Gynecology.

Each candidate in Group 3 will be expected to appear before the examiner or assistant examiner in the territorial district in which the candidate resides, unless special arrangements otherwise have been made in advance through the Secretary, for the written examination on March 14th. He should notify the Secretary before February 21st as to which of the two cities of his district he will present himself for examination so that his credentials may be forwarded to the proper examiner in advance. The territorial districts, the examiners' names, and the places of examination, appear below.

In each instance the examination papers and case records will be sent to be reviewed and marked by an examiner in another district from that in which the candidate resides and tries his examination.

TERRITORIAL DISTRICTS

3. Pennsylvania, New Jersey, Delaware, Maryland, Virginia, West Virginia, District of Columbia. Examiner: Dr. Edward A. Schumann, Philadelphia. Assistant Examiner: Dr. Emil Novak, Baltimore.

The practical or oral examination in Philadelphia on June 6th is scheduled to precede by one day the annual meeting of the American Medical Association.

Candidates in Groups 2 and 3 will report to the entire Board in Philadelphia on June 6th through the direction of Dr. Edward A. Schumann of Philadelphia.

Candidates will be notified individually, later, of the exact address at which their examinations will be held.

For further information address the Secretary.

Facts About Quacks

A BROADCAST FROM WGY

The radio is now one of the most useful means of spreading honest, practical public health counsel. We have found that WGY, and other outstanding broad-

casting stations, are always willing to co-operate for the public good.

"But, unfortunately, the radio can be a two-edged sword—as useful to quacks and commercial healers as to legitimate medical men and organizations. While reputable persons have broadcast health talks under the auspices of state and city departments of health and given helpful and honest advice over large stations, many charlatans, fake doctors and peddlers of strange medicines have used the smaller unsupervised stations as platforms from which to cry their spurious wares.

We found that many individuals who represented themselves over the radio as physicians, and gave advice on medical matters were not licensed physicians at all. Self-dosing with numerous quack medicines for a variety of ailments was being urged. Pills, so-called "health foods," compounds supposed to contain roughage, and other patented preparations, were being fraudulently advertised as scientific products made under the direction of physicians.

We found, in short, that virtually all of the various faddists, exploiters, and the like, who of recent years have been barred from advertising in reputable newspapers and magazines had taken to the radio, where, particularly in smaller stations, they had found a new haven of activity.

The danger of this is that the charlatan now gains direct access to the family circle, through the radio. His manner is so clever that you can not tell whether his advice is genuine or whether he is merely trying to sell you something which for your health's sake you should not have.

In many cases the devices or medicines sold by these radio fakers have power neither to cure nor to destroy. The menace of those apparently harmless frauds lies in the fact that they do no good. They induce a false sense of security, which may cause the patient to neglect his disease until it is too late.

If you have anything wrong with you, go to a competent physician. Do not make a diagnosis yourself or let a patent medicine man do it for you.

Beware also of radio speakers who advocate systems of healing which they claim may be applied hit-or-miss to all diseases. Such advice is open to even greater suspicion when offered in connection with the sale of imposing contraptions, and so-called "shot-gun" pills, alleged to contain an herb for each symptom.

Do not be deceived by testimonials. Any medical faker, if necessary, can summon hundreds and even thousands of testimonials to convince a prospective customer or a jury of the value of his treatment.

It is also easy for a smooth and plausible talker to persuade a chronic sufferer that he is being helped by a treatment which is doing him no good.

Persons who are ill with a chronic disease are always eager—sometimes pathetically eager—to be convinced that they can be cured, and cured speedily. Consequently they convince themselves, often against the evidence of their eyes and other senses, that they are being benefited.

The experienced quack understands this human quirk, and hence is eager and willing to offer free trials of his machine or medicine. It is natural for a sick person to try any cure offered him. The hope and enthusiasm thus aroused may perhaps help him temporarily. An honest and ethical physician will never promise or guarantee cures; for this reason he is hardly on a competitive basis

with the quack who is willing to guarantee anything and promise everything.

It is well to remember that the quack, who has an appliance or remedy to sell, is willing to prescribe on the diagnosis of the patient and without a thorough examination. He is not interested in your health; he is interested in your money.

When in doubt as to the reliability of health advice heard over the radio, write to the State Department of Health at Albany.

The Presidential Finger Slips

Norman Baker of Muscatine, Iowa, who claims to treat successfully cancer, goiter, varicose veins, and other diseases by some secret preparations, who uses his radio station to sell cigars and get patients, who attacks most of the reputable educational institutions and scientific organizations of his State and of the nation with billingsgate and vilification, found it necessary to start a newspaper to spread his views because the reputable press of his State exposed his quackery. By some of the strange influences known only to politicians, President Herbert Hoover was induced to apply to a pushbutton in Washington the presidential digit, thereby giving to the presses in Muscatine the electrical juice necessary to induce motion, whereby inked rollers applied to paper aided still further the dissemination of Baker's notions and nostrums. As an engineering feat, the demonstration must have given joy to the presidential cerebrum. As a demonstration of presidential judgment and a sense of the fitness of things, it gave acute pain to the press, the physicians, and most of the people of Iowa. Somewhere, somehow, some secretary succeeded in precipitating the President of the United States into a situation that awaits explanations—*Jour. A. M. A.*

Cancer Institute Head Sues Societies

Muscatine, Iowa, Jan. 17—Suit for \$100,000 damage was filed today against the American Medical Association and the Iowa State Medical Society, and the Muscatine County Medical Society by Norman Baker.

Baker, who is head of a cancer-treating institute which has been opposed by medical societies, charged the three societies with conspiracy to injure him by allegedly attempting to close his hospital and shut down his radio Station KTNT.

—A. P.

Acute Intestinal Obstruction

Frank Smithies, Chicago (*Journal A. M. A.*, Dec. 20, 1930), summarizes his experience with fifty-six patients affected with acute, intestinal obstruction. Fifty-two had abdominal section; two came to autopsy without operation, after perforating; two recovered without operation. In the last two patients, proof of acute intestinal obstruction was adequate, clinically, at the time, and later was proved by roentgen and physical examination. The patients came from families of moderate circumstances; there were no malnourished or destitute folk on whom any major operative procedures would not be well borne or who, through poverty or ignorance, might not consult physicians when illness appeared. The mortality of 41 per cent, therefore, does not arise because low intelligence or poverty kept patients away from medical management when first they became ill. Of those dying, only three patients appeared within 24 hours of the onset of trouble, five from 24 to 48 hours, two within 48 to 72 hours and as many as ten later than 72 hours. Several were as late as 150 hours. Other things being equal, the mortality is in direct ratio to the delay in seeking relief. Acute obstruction from bands and adhesions occurred in forty-four patients (79 per cent). Their most common site was in the right lower quadrant, affecting the ileum most frequently. The mid and upper jejunum was next in point of frequency. Then followed in order the sigmoid, the transverse and the ascending portions of the colon. Volvulus was observed in the ileum or the jejunum five times; intussusception (through the ileocecal valve) twice; hernia of the ileum through the broad ligament three times; involvement of the ileum with the ovary and tube, three times; cancer, perforating and followed by abscess which involved the lower ileum or the jejunum, three times; acute ileus, twice; ulceration of the ileum with perforation and obstruction, three times; adhesive obstructing bands from the viscera (gall bladder, stomach, spleen, liver), six times; mesenteric thrombosis, once. The obstruction was so acute and so complete that gangrene complicated the operative procedures, requiring resection of the viscera, in thirteen cases. The mortality was 85 per cent in this group in spite of prompt action, skilled surgery, blood

transfusions, draining the proximal portion of the affected intestine and all known forms of supportive treatment. While all patients in whom acute intestinal obstruction is diagnosed or is suspected are immediately or, potentially, surgical subjects, the internist may be of help in sending the patient to the surgeon as a reasonably good operative risk. Mouth feeding should be interdicted, gastric or intraduodenal lavage by the Rehfuß tube (introduced by a stiff wire stylet) begun early, catharsis forbidden and fluid (physiologic solution of sodium chloride or Ringer's solution) given into the colon by rectal drip and constantly. Abdominal examination, made early and often repeated, may locate the place of obstruction and give information relative to the occurrence of gangrene, perforation or abscess. "Scout films" should be made whenever possible; study of the gas shadows may prove of great importance in locating the obstruction, giving information as to the degree of proximal dilatation, indicating a perforation or aiding the surgeon in planning his operative procedure. The leukocytes should be counted hourly; an ascending count, with frequent and thready pulse, means extension of inflammation and a bad prognosis. So, also, does a lowered count, when the leukocyte response had originally been brisk, particularly when accompanied by a drop in temperature and rise in pulse, but a fall in blood pressure. Peristalsis should be stopped by injections of morphine, preferably given intravenously when shock is present. Locally, if perforation or gangrene is suspected, attempts should be made early to localize the pathologic condition by the application of ice bags. If perforation has not taken place, large, hot dressings saturated with alcohol and boric acid should cover the abdomen. As early as possible, studies of the blood chlorides, carbonates, calcium and nonprotein nitrogen should be made, particularly in the presence of constant regurgitation or vomiting. Falling of the alkaline radicals with increase of the nitrogenous bodies indicates a bad prognosis unless there is prompt and vigorous attempt made to counteract the phenomenon by continuous administration (preferably intravenously) of solutions of sodium chloride and sodium bicarbonate or Ringer's solution. This procedure often is a life-saving one, whether instituted before or after surgery or both. And, finally, from the beginning, the internist should be in the closest co-operation with a skilled, conservative and scientifically trained surgeon.

Incidence of Hemorrhage in Perforated Gastric and Duodenal Ulcers

Moses Behrend, Philadelphia (*Journal A. M. A.*, Dec. 20, 1930), states that perforated ulcers rarely bleed; bleeding ulcers rarely perforate. In his opinion that to defer operation for bleeding ulcer in the hope that the ulcer may not bleed again is an error of judgment. Perforative ulcers occur more frequently than bleeding ulcers. The fact that bleeding ulcers rarely perforate and perforated ulcers rarely bleed may be explained by anatomic, physiologic, and pathologic observations. Anatomically, there is a bloodless area around the pylorus responsible for some of the deductions; physiologically, the exuding juices prevent hemorrhage, while pathologically the age of the ulcer determines whether it is going to bleed or not.

BOOK REVIEWS

How It Happened. By Adalbert G. Bethman, M. D. Pp. 110. Cloth. \$1.00. Philadelphia: F. A. Davis Company, 1931.

This little book of blank verses is evidently written for the doctor's waiting room. It consists of episodes taken from any doctor's experience, and runs the whole gamut of "do's," "don'ts," "if I only had," "if only I had not," "too late," etc. The idea, while not new, is cleverly carried out, though in some places the blank verse is so blank it can hardly be called verse. The book is propaganda, frankly and plainly, but mighty good propaganda, and as such ought to be seen on many a waiting room table.

Physical Diagnosis. By Warren P. Elmer, M. D., Associate Professor of Clinical Medicine, Washington University, and W. D. Rose, M. D., Late Associate Professor of Medicine, University of Arkansas. Pp. 903, with 337 illustrations. Cloth. Price, \$10.00. St. Louis: C. V. Mosby Company, 1930.

Dr. Elmer's revision of the late Dr. Rose's popular book is most complete. The book is now divided into two parts: first, technique of examination and normal physical diagnosis; and second, physical diagnosis of disease (respiratory and circulatory). The text is clear, at times rather terse, but generally quite ample. Much clinico-pathological material is interwoven. Part II would make an excellent separate monograph on diseases of the heart and lungs. The typography is unusually good; the illustrations excellent, especially those from xrays. The index is exceptionally well done. There is not much to quibble with in this book; it is really an excellent work.

MEDICAL SOCIETY OF DELAWARE

OFFICERS AND COMMITTEES FOR 1931

FIRST VICE-PRESIDENT: W. F. Haines, Seaford
 SECRETARY: W. O. LaMotte, Wilmington

SECOND VICE-PRESIDENT: C. J. Prickett, Smyrna
 TREASURER: Samuel C. Rumford

J. W. Bastian, Wilmington

COUNCILORS
 U. W. Hocker, Lewes
 DELEGATES

Joseph Bringham, Felton

To A. M. A. 1931-1932 Robert W. Tomlinson
 To Maryland Society
 To Pennsylvania Society
 To New Jersey Society
 To New York Society
 To State Pharmaceutical Society

Alternate, P. W. Tomlinson
 Henry V. P. Wilson, Dover
 James Beebe, Lewes
 Lewis Booker, New Castle
 A. J. Strikol, Wilmington
 Samuel Marshall, Milford

STANDING COMMITTEES

COMMITTEE ON SCIENTIFIC WORK

M. A. Tarumianz, Farnhurst

Stanley Worden, Dover

COMMITTEE ON PUBLIC POLICY AND LEGISLATION

J. H. Mullin, Wilmington

W. O. LaMotte, Wilmington

Wm. Marshall, Milford

COMMITTEE ON PUBLICATIONS

W. O. LaMotte, Wilmington

M. A. Tarumianz, Farnhurst

COMMITTEE ON MEDICAL EDUCATION

J. S. McDaniel, Dover

Wm. Marshall, Milford

COMMITTEE ON HOSPITALS

C. C. Deakyne, Smyrna

Catherine Cross, Lewes

COMMITTEE ON NECROLOGY

L. C. Conwell, Camden

W. P. Orr, Lewes

SPECIAL COMMITTEES

COMMITTEE ON CANCER

G. C. McElfrick, Wilmington

J. R. Elliott, Laurel

M. A. Tarumianz, Farnhurst

James Beebe, Lewes

Henry Wilson, Dover

W. J. Marshall, Milford

COMMITTEE ON SYPHILIS

C. E. Wagner, Wilmington

B. S. Vallett, Wilmington

COMMITTEE ON HEALTH PROBLEMS IN EDUCATION

W. R. Pierce, Milford

W. P. Orr, Lewes

E. F. Smith, Georgetown

COMMITTEE ON HOSPITAL SURVEY

J. M. Barsky, Wilmington

Henry Wilson, Dover

W. H. Speer, Wilmington

O. V. James, Milford

M. A. Tarumianz, Farnhurst

Wm. Marshall, Milford

COMMITTEE ON LIBRARY

Julian Adair, Wilmington

G. W. K. Forrest, Wilmington

W. O. LaMotte, Wilmington

E. R. Mayerberg, Wilmington

A. J. Strikol, Wilmington

V. D. Washburn, Wilmington

ADVISORY COMMITTEE, WOMAN'S AUXILIARY

I. J. MacCollum, Wyoming

C. A. Sargent, Dover

Richard Beebe, Lewes

NEW CASTLE COUNTY MEDICAL SOCIETY—1931

Meets the Third Tuesday

JEROME D. NILES, *President*, Middletown.
 GEORGE W. VAUGHAN, *Vice-President*, Wilmington.
 DOUGLAS T. DAVIDSON, *Secretary*, Claymont.
 LOUIS S. PARSONS, *Treasurer*, Wilmington.

Delegates: Julian Adair, W. Edwin Bird, Lewis Booker, I. L. Chipman, Walter W. Ellis, G. W. K. Forrest, Dorsey W. Lewis, W. V. Marshall, L. S. Parsons, H. L. Springer, P. W. Tomlinson, J. P. Wales. Alternates: Olin S. Allen, L. Heisler Ball, Joseph M. Barsky, J. W. Butler, D. T. Davidson, T. H. Davies, C. M. Hanby, L. J. Jones, Emil R. Mayerberg, Meredith I. Samuel, Brice S. Vallett.

Board of Directors: Jerome D. Niles, D. T. Davidson, L. Heisler Ball, Ira Burns, R. W. Tomlinson.

Board of Censors: J. M. Barsky, James W. Butler, C. P. White.

Program Committee: George W. Vaughan, J. D. Niles, D. T. Davidson.

Legislation Committee: G. W. K. Forrest, John H. Mullin, J. P. Wales.

Membership Committee: Olin S. Allen, John C. Pierson, Willard E. Smith.

Necrology Committee: L. J. Jones, B. M. Allen, H. G. Bradley.

Nomination Committee: Earl Bell, I. L. Chipman, C. C. Neese.

Audits Committee: W. F. Preston, H. W. Gray, R. A. Lynch.

Public Relations Committee: A. J. Strikol, E. R. Mayerberg, C. E. Wagner.

Credit Bureau Committee: Norwood W. Voss, W. E. Bird, Paul R. Smith.

KENT COUNTY MEDICAL SOCIETY—1931

Meets the First Wednesday

DR. C. A. SARGENT, *President*, Dover.
 DR. OGBURN, *Vice-President*, Dover.
 DR. C. B. SCULL, JR., *Secretary-Treasurer*, Dover.
 Censors: Dr. W. C. Deakyne of Smyrna, 1930; Dr. J. W. Martin of Magnolia, 1931; Dr. S. M. D. Marshall of Milford, 1932.

Delegates: Dr. L. S. Conwell of Camden, 1930; Dr. J. S. McDaniel of Dover, 1931; Dr. Joseph Bringham of Felton, 1932. Alternate: Dr. Willard R. Pierce of Milford.

SUSSEX COUNTY MEDICAL SOCIETY—1931

Meets the Second Thursday

KENDALL J. HOCKER, *President*, Millville.
 WILLIAM P. ORR, *Vice-President*, Lewes.
 ERNEST F. SMITH, *Secretary*, Georgetown.

Committee on Entertainment: Bruce Barnes, U. W. Hocker. Visiting Committee: W. F. Haines, Robert Hopkins, K. J. Hocker.

Committee on Nominations: U. W. Hocker, O. V. James, H. M. Manning.

DELAWARE STATE BOARD OF HEALTH—1931

W. P. Orr, M. D., *President*, Lewes; Mrs. Charles Warner, *Vice-President*, Wilmington; Robert Ellegood, M. D., *State Road*; Willard R. Pierce, M. D., *Milford*; Mrs. Frank G. Tallman, *Wilmington*; Margaret Handy, M. D., *Wilmington*; Mrs. Arthur Brewington, *Delmar*; C. R. Jeffries, D. D. S., *Wilmington*; Arthur C. Jost, M. D., *Dover*, *Executive Secretary and Registrar of Vital Statistics*.

DIVISIONS

Child Hygiene, Cleland A. Sargent, M. D.; Sanitation, Richard C. Beckett, B. Sc.; Laboratory, Roland D. Herdman, B. Sc.; Brandywine Sanitarium, Lawrence D. Phillips, M. D. and Edgewood Sanitarium, Elizabeth K. Van Vranken, M. D.; New Castle County Health Unit, R. C. Strode, M. D.; Sussex County Health Unit, E. F. Smith, M. D.

DELAWARE PHARMACEUTICAL SOCIETY—1931

WALTER R. KEYS, *President*, Clayton.
 HEWITT K. McDANIEL, *Dover*, GEORGE E. SWAIN, *Georgetown*, *Vice-Presidents*.

ALBERT DOUGHERTY, *Secretary*, Wilmington.
 PETER F. BIENKOWSKI, *Treasurer*, Wilmington.

Board of Directors: Walter R. Keys, James W. Wise, George W. Rhodes, Albert S. Williams, Walter L. Morgan.

WOMAN'S AUXILIARY, M. S. OF D.—1931

MRS. ROBERT W. TOMLINSON, *President*, Wilmington.
 MRS. JOSEPH McDANIEL, *Vice-President for Kent County*, Dover.
 MRS. WILLIAM P. ORR, *Vice-President for Sussex County*, Lewes.
 MRS. M. A. TARUMIANZ, *Treasurer*, Farnhurst.
 MRS. LAWRENCE JONES, *Secretary*, Wilmington.
 MRS. W. EDWIN BIRD, *Editor*, Wilmington.

